Mary Costello Stevens, LPC
7000 Belleview Ave. Suite 350
Greenwood Village, Colorado 80111
Phone: 303-380-7070

Release of Information

This document, signed by the client, allows information to be shared by the client's therapist to a third party. Information may also be shared from the third party to the client's therapist.

I,_____ agree to allow Mary Costello Stevens, to release the following information regarding my (my child's) treatment, including information about diagnosis, medical information, history, previous treatment, current treatment & progress, for purposes of further evaluation and/or continuity of care. Information may also be obtained from the third party by the therapist. Use this space for specific instructions regarding information to be shared if necessary: _____
_____
_____
_____.

With whom information may be exchanged:

Primary Care Physician: YES_____ NO_____

Psychiatrist: YES____NO____ N/A____ if yes, write name and contact number: _____
_____

If using insurance, information must be provided to for ongoing authorization & billing. Please indicate the Name of your Insurance Company Please:_____

Other individual(s) with whom information may be exchanged (please write names and contact #'s):
_____
_____
_____
_____
_____

_____ _____
Signature of Client (parent if under 18) Date

_____ _____
Mary Costello Stevens, LPC Date